SENTARA COMMUNITY PLAN
(MEDICAID)

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-844-305-2331**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization will be delayed.**

Drug Requested: Camzyos® (mavacamten)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

Quantity limit: 1 capsule per day

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 8 months

- ❑ Member is 18 years of age or older
- ❑ Prescribed by or in consultation with a cardiologist specialist
- ❑ Member has a diagnosis of symptomatic obstructive hypertrophic cardiomyopathy (HCM)
- ❑ Member had an adequate echocardiogram or cardiovascular magnetic resonance imaging (CMR)
- ❑ Member has New York Heart Association (NYHA) class II-III symptoms

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- ❑ Baseline peak oxygen consumption (pVO2) determined by cardiopulmonary exercise testing (CPET) has been submitted
- ❑ Member has documented left ventricular ejection fraction (LVEF) ≥ 55%
- ❑ Member has a left ventricular outflow track (LVOT) gradient of 50 mmHg or higher
- ❑ Member remains symptomatic despite trial of, or intolerant to at least **TWO** of the following **(verified by chart notes or pharmacy paid claims)**:
  - ❑ Beta-blocker (e.g., metoprolol, carvedilol)
  - ❑ Calcium channel blocker (e.g., verapamil, diltiazem)
  - ❑ disopyramide
  - ❑ Septal reduction therapy
- ❑ Member will avoid concomitant use with moderate to strong CYP2C19 inhibitors/inducers, strong CYP3A4 inhibitors/inducers
- ❑ Member will avoid concomitant dual therapy with beta-blockers and calcium channel blockers or monotherapy with disopyramide or ranolazine
- ❑ Member will **NOT** take disopyramide in conjunction with the requested medication

Reauthorization: 12 months. All criteria that apply must be checked for approval. To support each line checked, all documentation (lab results, diagnostics, and/or chart notes) must be provided or request may be denied.

- ❑ Member has experienced continued clinical benefit as demonstrated by at least **ONE** of the following:
  - ❑ Improvement of at least 1.5 mL/kg/min in peak oxygen consumption (pVO2) as determined by cardiopulmonary exercise testing (CPET) AND a reduction of ≥ 1 New York Heart Association (NYHA) functional classification (e.g., I, II, III, or IV)
  - ❑ Improvement of at least 3.0 mL/kg/min in pVO2 with no worsening in NYHA functional classification
- ❑ Member has **NOT** experienced any treatment-restricting adverse effects (e.g., heart failure, LVEF <50%) while taking requested medication
- ❑ Provider has submitted the results of member's most recent echocardiogram or cardiovascular magnetic resonance imaging obtained after starting the requested medication

Medication being provided by Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.
Previous therapies will be verified throu.gh pharmacy paid claims or submitted chart notes.